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Issue Date: 30 September 2005

IN THE MATTER OF:

AGNES E. SCHUTT (widow of and
on behalf of Benedict S. Schutt),
Claimant,

v. Case No.: 2001-BLA-1010

KNIFE RIVER COAL CO.,
Employer,

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest.

DECISION AND ORDER ON REMAND AWARDING BENEFITS

On March 29, 2005, the Benefits Review Board (Board) affirmed certain findings in the undersigned Administrative Law Judge's March 9, 2004 *Decision and Order,* and remanded this matter for reconsideration of certain other issues. In particular, the following findings were upheld:

· Claimant demonstrated that the miner suffered from coal workers' pneumoconiosis pursuant to 20 C.F.R. §§ 718.202(a)(2) and (a)(4);

· It was proper to accord greatest weight to the autopsy report of Dr. Dikman because it was the most well-reasoned and well-documented;

· The undersigned Administrative Law Judge properly found that Dr. Kleinerman diagnosed the presence of mild simple coal workers' pneumoconiosis on autopsy;

· The miner worked in the mines for 28 years;

· It was proper to use the *Dictionary of Occupational Titles* to find that the miner's last job as a dragline operator constituted "medium" labor; and

· Pneumoconiosis was not established under 20 C.F.R. §§ 718.202(a)(1) and (a)(3) of the regulations;

· Total disability was not demonstrated under 20 C.F.R. §§ 718.204(b)(2)(i) or (iii) of the regulations; and

· In the event that benefits are awarded on remand, the undersigned's June 18, 2004 *Supplemental Decision and Order Awarding Representative's Fee* was affirmed.

The issues presented on remand for reconsideration are as follows:

· Where Dr. Dikman diagnosed pulmonary emphysema and Drs. Naeye, Spagnolo, Kleinerman, Caffrey, and Hutchins diagnosed centrilobular emphysema, the opinions must be reconsidered to determine whether the miner's emphysema is related, in part, to his coal dust exposure;

· Although all of the physicians conclude that the miner is totally disabled, the opinions must be reweighed to determine whether the total disability is respiratory or cardiac in nature; and

· Because the report of Dr. Graham, which is attached to the deposition of Dr. Dolan at *Claimant's Exhibit* 15A, was never formally admitted into the record as a separate exhibit, it must be determined whether the opinion is properly of record[1];

Finally, in light of the foregoing findings, it must be determined whether the miner's (1) total disability and/or (2) death were due to coal workers' pneumoconiosis.

I
Emphysema due to coal dust exposure

Although the Board upheld the undersigned Administrative Law Judge's finding that the miner suffered from coal workers' pneumoconiosis under 20 C.F.R. §§ 718.202(a)(2) and (a)(4), it redirected reconsideration of the autopsy and medical reports on remand to determine whether the miner's emphysema was due, in part, to coal dust exposure.

Of the pathologists, the Board noted that Drs. Naeye, Kleinerman, Caffrey, and Hutchins diagnosed the presence of centrilobular emphysema, whereas Dr. Dikman diagnosed pulmonary

[1] Dr. Graham's report was summarized and included in the undersigned Administrative Law Judge's original *Decision*, but will be omitted for purposes of this remand decision at Employer's request. Upon review of the hearing transcript and Dr. Dolan's deposition transcript, it is noted that the report was never formally offered and admitted as evidence. Although Dr. Dolan referred to Dr. Graham's findings during his deposition testimony, Dr. Dolan's opinion is supported by other probative reports and testing of record such that it is not adversely affected by consideration of Dr. Graham's report. Indeed, Dr. Graham focused on whether the miner suffered from asbestosis and, as with other qualified physicians of record, he concluded that the miner did not.

emphysema. The Board also required that the opinion of Dr. Spagnolo, who is board-certified in internal medicine, be reweighed with regard to the cause of the miner's centrilobular emphysema. Drs. Naeye, Caffrey, and Spagnolo opined that centrilobular emphysema is caused by cigarette smoking, not coal dust exposure.

Consideration of Departmental findings after formal rulemaking

In assessing the physicians' opinions on this issue, it is proper to consider the Department's findings underlying promulgation of the amended regulations on December 20, 2000. *See* 65 Fed. Reg. 79920 (Dec. 20, 2000). Citation to the Department's medical findings underlying the amendments is proper for three reasons.

First, it is noted that the amended definition of "pneumoconiosis" at 20 C.F.R. § 718.201 (2004) is applicable to this claim pursuant to 20 C.F.R. § 718.2 (2004). *See also National Mining Ass'n. v. Dep't. of Labor*, 292 F.3d 849 (D.C. Cir. 2002). Consequently, medical findings contained in comments in support of the amended definition of pneumoconiosis at 20 C.F.R. § 718.201 (2004) are relevant.

Second, it is not unusual for courts to cite to, and consider, published comments underlying the promulgation of regulations. *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 156 n. 29 (1988) (favorable discussion of the Department's comments underlying promulgation of 20 C.F.R. § 727.203(a) to determine that the agency did not intend that a single piece of qualifying evidence be sufficient to invoke the interim presumption); *Consolidation Coal Co. v. Director, OWCP [Stein]*, 294 F.3d 885, 892 (7th Cir. 2002) (favorable consideration of the Department's December 2000 comments with regard to use of CT-scans in assessing the presence or absence of pneumoconiosis); *Bonessa v. United States Steel Corp.*, 884 F.2d 726, 729 (3rd Cir. 1989) (favorable referral to the Department's 1983 comments to 20 C.F.R. § 718.205(c) in assessing causation). Therefore, consideration of the Department's findings as set forth in the comments to the amended regulations is proper.

Third, according deference to the Department's medical findings after public rulemaking proceedings is proper. Indeed, the findings are based on an extensive public notice and comment rule-making period conducted in compliance with the strictures of the Administrative Procedures Act (APA). The comments are the product of the Department's extensive review of medical literature, studies, articles, and reports from a variety of medical experts and organizations, including the National Institute of Occupational Safety and Health (NIOSH), which is the congressionally mandated medical advisor for the Black Lung program. After considering divergent expert medical opinions from multiple sources, the agency made certain findings regarding the nature and characteristics of pneumoconiosis that are entitled to deference. As noted by the Seventh Circuit, when it favorably considered the Department's comments regarding use of CT-scans in *Stein*, it is proper to "defer to the Department of Labor's reasonable judgment in resolving complex, technical issues that draw upon its familiarity and expertise with the diagnosis, prevention, and remediation of black lung disease." *Id.* at 892.

Departmental findings regarding cause of centrilobular emphysema

In its comments, the Department noted that medical data supported a finding that "[c]entrilobular emphysema . . . was significantly more common among the coal workers." 65 Fed. Reg. at 79941 (Dec. 20, 2000). Indeed, the "severity of the emphysema was related to the amount of dust in the lungs" and "[t]hese findings held even after controlling for age and smoking habits." 65 Fed. Reg. at 79941 (Dec. 20, 2000). In one study, which involved pathological review of the lungs of 450 coal miners, the authors of the study found "emphysematous changes in 72% of miners who smoked, 65% of ex-smokers, and 42% of non-smoking miners . . .." 65 Fed. Reg. at 79942 (Dec. 20, 2000).

Consequently, while the cause of a particular miner's emphysema must be determined from the medical evidence in each particular claim, the probative value of a physician's opinion may be affected by views that are inconsistent with findings made by the Department during its rulemaking proceedings.

Etiology of emphysema in this claim

The Board notes that Dr. Dikman diagnosed the presence of pulmonary emphysema based on his review of the miner's lung tissue. Drs. Naeye, Kleinerman, Spagnolo, Caffrey, and Hutchins diagnose the presence of centrilobular or centriacinar emphysema.

With regard to etiology of the emphysema, although Dr. Kleinerman observed the presence of centriacinar emphysema on gross examination of the lung tissue, he did not state the cause of the emphysema. Similarly, Dr. Hutchins noted the presence of a mild to moderate degree of centrilobular emphysema without specifically stating its cause. As a result, the opinions of Drs. Kleinerman and Hutchins are not probative on the issue of the cause of the miner's emphysema.

Dr. Caffrey noted "[f]ocal areas of centrilobular emphysema" and stated the following with regard to its cause:

> The patient was a very heavy smoker for years, although apparently he did not smoke for a number of years prior to his death, but I believe the years of smoking cigarettes caused him pulmonary impairment, particularly chronic bronchitis and centrilobular emphysema.

It is not clear whether Dr. Caffrey's opinion is based on a premise that coal dust exposure cannot cause centrilobular emphysema in general, which is contrary to the Department's findings, or whether coal dust exposure did not contribute to development of the miner's centrilobular emphysema in this particular case, which is not adequately explained in light of Claimant's lengthy mine exposure history. As a result, Dr. Caffrey's opinion is less probative.

Dr. Naeye also found the presence of centrilobular emphysema, but concluded that it was the result of the Claimant's long-term tobacco abuse. In explaining his opinion regarding the cause of the emphysema, Dr. Naeye stated that "smoking has about three times the role of mine dust exposure in terms of causing centrilobular emphysema." In the March 2004 *Decision,* the undersigned Administrative Law Judge found that, based on the foregoing statement, Dr. Naeye

acknowledged that coal dust exposure was also a contributing factor in the development of Claimant's emphysema, albeit to a lesser extent than smoking. The Board held to the contrary and stated the following:

> We agree with employer's argument that Dr. Naeye's statement, 'that from people who have smoked, the smoking has about three times the role of mine dust exposure in terms of causing centrilobular emphysema,' is merely a summary of the medical literature in general, and was mischaracterized by the administrative law judge as a medical opinion that coal dust played a role in the development of this specific miner's centrilobular emphysema. (citations omitted). Therefore, as Dr. Naeye's statement does not constitute affirmative evidence of a causal relationship between the miner's diagnosed centrilobular emphysema and his coal mine employment sufficient to support claimant's burden to establish entitlement . . ..

(Slip op. at 7-8). The undersigned has, again, reviewed Dr. Naeye's testimony with regard to the cause of the miner's centrilobular emphysema and the only explanation Dr. Naeye provided to support his opinion with regard to causation in this claim is the above-quoted "general" proposition. Thus, generally smoking and coal dust play a role in the development of centrilobular emphysema at a ratio of three to one according to Dr. Naeye. Dr. Naeye does not then explain how he concludes that the miner's emphysema is solely attributable to smoking in this case. For this reason, his report is less persuasive.

Similarly, Dr. Spagnolo attributed the miner's respiratory impairment, in part, to centrilobular emphysema stemming from tobacco abuse. In his October 2003 deposition, Dr. Spagnolo opined that centrilobular emphysema is caused by cigarette smoking, whereas focal emphysema is associated with coal dust exposure. Because the miner was diagnosed with "centrilobular" emphysema, the condition was not caused by coal dust exposure. He further stated that the miner did not have "bronchiolitis" and this condition is typically absent from persons suffering from focal emphysema as well as persons with centrilobular emphysema who are no longer smoking. Thus, the absence of bronchiolitis in this case, standing alone, is not indicative of whether the miner's emphysema in this case was caused by coal dust exposure or smoking or both. However, Dr. Spagnolo's premise that centrilobular emphysema is caused solely by cigarette smoking in general is inconsistent with Dr. Naeye's general opinion regarding the causes of centrilobular emphysema. It is also inconsistent with the Department's findings on the issue. Consequently, Dr. Spagnolo's opinion is accorded less weight.

On the other hand, Dr. Dikman repeatedly found emphysema in the miner's lungs. He noted the presence of "mild emphysema . . . and carbon pigment deposits" as well as "variable interstitial fibrosis, (and) mild to moderate areas of pulmonary emphysema" in the miner's lungs. Dr. Dikman concluded that the miner had "pneumoconiosis attributed to inhaled silicates consistent with coal dust exposure" and "[t]hese changes were superimposed on pulmonary emphysema." He further opined that Claimant "had chronic lung disease with pulmonary emphysema and findings of dust related pneumoconiosis." The Board has upheld the undersigned Administrative Law Judge's determination that Dr. Dikman's pathology report was well-documented and well-reasoned. Although it is not clear whether Dr. Dikman opines that

the miner's emphysema is related to coal dust exposure, Dr. Dolan reviewed Dr. Dikman's thorough autopsy findings as well as certain other medical records and specifically attributed the miner's emphysema to his long-term coal mining and smoking histories. *Claimant's Exhibit* 15A. Dr. Dolan further stated:

> Emphysema has repeatedly been demonstrated in coal miners at levels greater than those of controls. According to the section on respiratory disease in Rom's Environmental and Occupational Medicine, studies indicate a causal relationship between emphysema and coal dust exposure with an ensuing potential for disability.

This premise is consistent with the Department's position on the development of centrilobular emphysema.

On balance, it is determined that Dr. Dolan's opinion, as supported by the report and observations of Dr. Dikman, is the most persuasive. In particular, Dr. Dolan's opinion is well-documented as it is based on undisputed findings of emphysema in the miner's lungs on autopsy as well as proper consideration of Claimant's lengthy smoking and coal mining histories. Moreover, Dr. Dolan clearly premised his opinion on a view that is consistent with the Department's findings during rulemaking, *i.e.* coal dust exposure *may* cause the development of centrilobular emphysema.

II
Totally disabling respiratory impairment

As noted in the undersigned Administrative Law Judge's March 2004 *Decision*, the physicians agree that Claimant is totally disabled. However, the Board has instructed the undersigned to re-weigh the medical opinions to determine whether the miner suffered from a totally disabling *respiratory* condition, or whether his total disability stems from cardiac problems.

Notably, at pages 48 through 51 of the March 2004 *Decision*, the various opinions as to whether the miner's disability was respiratory or cardiac in nature are discussed at length. In sum, Drs. Morgan, Kleinerman, Naeye, and Hutchins, Spagnolo concluded that the miner's total disability stemmed from his cardiac problems. Drs. Fino, and Respher concluded that a respiratory impairment was present, but it was not necessarily totally disabling. Drs. Dolan and Kriengkairut concluded that the miner suffered from a totally-disabling respiratory impairment. In his June 2002 report, Dr. Castle opined that the miner "probably" did not retain the respiratory capacity to perform his last coal mining job. Dr. Caffrey opined that the miner suffered from a respiratory impairment at the time of death, but he did not state the extent of the impairment.

Of the foregoing physicians' opinions, the opinions of Drs. Kriengkairut and Dolan are the most well-documented and well-reasoned with regard to the nature of the miner's disability. Importantly, during the most recent comprehensive examination of the miner, which was conducted by Dr. Kriengkairut in 1995, he observed that the miner suffered from dyspnea on

exertion. During exercise, the miner's maximum oxygen consumption was 17.5. Dr. Dolan testified during his deposition that the test revealed that the miner "wasn't even able to reach his maximum predicted heart rate because of shortness of breath." On the other hand, Dr. Kriengkairut's testing of the miner's *cardiovascular* system during that examination revealed a normal response to exercise. As a result, Dr. Kriengkairut reasonably concluded that the miner's disability was of a respiratory, not cardiac, origin.

Dr. Dolan agreed. He stated that the miner exhibited significant oxygen desaturation on exertion. Dr. Dolan noted the following in his report:

> (The miner) currently uses oxygen by nasal cannula. The latest pulmonary exercise test I have reviewed, dated 2/10/95, showed severe exercise limitation. He could only exercise at low exertion level for 6 minutes, dropping his oxygen saturation from 92 to 85. At an oxygen saturation of 90% (equaling a PO2 of approximately 60), most people will have the sensation of being short of breath. According to the physician's comments, his condition was worsening with time. On the basis of symptoms noted by his physician and corroborated by the exercise testing, Mr. Schutt cannot perform any reasonable work and presently seems to require supplemental O2 just for activities of daily living.

Dr. Dolan then testified during his deposition that, at the time of Dr. Kriengkairut's 1995 examination, the miner did not suffer from congestive heart failure:

> (The miner) didn't have congestive heart failure by that time. And actually the report says that he had a normal cardiovascular response to exercise, meaning no deconditioning and that he had an abnormal pulmonary response to exercise which the pulmonologist said was due to a mix-up of structural and restrictive defects . . ..
>
> So I think this test, if anything, shows that his heart rate, that his heart responses were normal, that he had no obvious deconditioning, although you would expect that he might have some. And that the disability and limitation was due to ventilatory or pulmonary limitation.

Cx. 15A at 77-78.

Drs. Morgan, Naeye, Kleinerman, Hutchins, Fino, Spagnolo, and Repsher fail to explain their opinions in light of the foregoing medical data, which the undersigned finds compelling. Additionally, the opinions of Drs. Kriengkairut and Dolan are better supported by the recent qualifying blood gas study data dated July 31, 1996, which the Board has upheld as supporting a finding a total disability under § 718.204(b)(2) of the regulations. *Minnich v. Pagnotti Enterprises, Inc.*, 9 B.L.R. 1-89, 1-90 n. 1 (1986) (a report that is better supported by the objective medical data of record may be accorded greater weight); *Wetzel v. Director, OWCP*, 8 B.L.R. 1-139 (1985).

The Board upheld the undersigned Administrative Law Judge's finding that Claimant last engaged in a coal mining job requiring "medium work." Specifically, at page 47 of the March 2002 *Decision*, "medium work" was defined in the *Dictionary of Occupational Titles* as:

> Exerting 20 to 50 pounds of force occasionally, and/or 10 to 25 pounds of force frequently, and/or greater than negligible up to 10 pounds of force constantly to move objects.

In Dr. Stoy's examination report, Claimant had stated that his last coal mining job required switching cables and "having to walk relatively fast in doing some of this work." Based on the well-reasoned and well-documented medical opinions of Drs. Kreingkairut and Dolan and the fact that Claimant requires the use of supplemental oxygen "just for activities of daily living," it is evident that the miner could not engage in his last coal mining job of switching cables, walking fast, or lifting objects weighing 10 to 50 pounds. Moreover, as previously discussed, testing underlying the reports of Dr. Kreingkairut demonstrated deficiencies in the miner's respiratory, as opposed to his cardiac, system. As a result, it is reasonable to find that Claimant suffered from a totally disabling respiratory impairment.

III
Total disability due to coal workers' pneumoconiosis

Having determined (1) that the miner suffers from mild simple coal workers' pneumoconiosis and mild to moderate emphysema stemming from his smoking and mining histories, and (2) that he had a totally disabling respiratory impairment, the evidence must be weighed in accord with the Board's direction to determine whether Claimant's impairment and death were due, in part, to these coal-dust-induced lung diseases. In this vein, the Board vacated the undersigned's findings on "disability causation and death due to pneumoconiosis" until the medical opinions were reweighed to determine whether the miner's emphysema was also coal dust related.

Since it is determined that the miner suffered from mild simple coal workers' pneumoconiosis as well as coal dust induced emphysema, the disability causation discussion in the March 2004 *Decision* is properly adopted here. In particular, the evidence of record establishes the presence of *clinical* coal workers' pneumoconiosis as well as *legal* pneumoconiosis, *i.e.* existence of mild to moderate levels of emphysema arising, at least in part, from coal dust exposure. Drs. Naeye, Caffrey, Hutchins, Stoy, Spagnolo, Repsher, and Morgan concluded that the miner's respiratory impairment, to the extent that he suffered from such an impairment, was due to his tobacco abuse, and not coal dust exposure. Consequently, these physicians' opinions are based on a premise in disagreement with the undersigned's findings on this record. Because Drs. Naeye, Caffrey, Hutchins, Spagnolo, Stoy, and Morgan did not find the presence of clinical or legal pneumoconiosis contrary to the undersigned's findings, their opinions are entitled to little weight with regard to the etiology of the miner's disability. *Scott v. Mason Coal Co.*, 289 F.3d 263 (4th Cir. 2002); *Toler v. Eastern Assoc. Coal Co.*, 43 F.2d 109 (4th Cir. 1995).

Drs. Kleinerman, Fino, Repsher, and Castle did state that the miner suffered from coal workers' pneumoconiosis based on the autopsy data of record. However, Drs. Kleinerman, Repsher, and Fino opined that there was an insufficient level of coal workers' pneumoconiosis on pathology to account for the oxygen transfer abnormalities revealed by the miner's testing. Similarly, Dr. Castle opined that "based upon the sparsity of findings in the pathologic specimens and the lack of physiologic impairment associated with coal workers' pneumoconiosis," the "process was so minimal as to have not caused him any impairment during life . . .." However, the preponderance of evidence of record supports a finding that the miner suffered from more than "minimal" or "insignificant" coal workers' pneumoconiosis. It is apparent that Drs. Kleinerman, Fino, Repsher, and Castle restricted their causation opinions to addressing the impact of *clinical* pneumoconiosis. Indeed, Dr. Castle testified that the miner did not suffer from *legal* pneumoconiosis during his deposition. Their opinions regarding causation are accorded little probative value because Drs. Kleinerman, Fino, Repsher, and Castle failed to consider the combined effects of the miner's mild simple coal workers' pneumoconiosis and mild to moderately severe coal dust induced emphysema. It is reasonable to conclude that the combined effects of these conditions on the miner's respiratory and pulmonary systems was not "minimal" or "insignificant." Importantly, Drs. Fino, Castle, and Repsher concluded that the miner's respiratory impairment contributed to his overall disability, although they opined that this impairment arose solely from tobacco abuse contrary to a preponderance of the evidence in this record.

As previously mentioned, Drs. Dolan and Kriengkairut persuasively opine that coal dust induced respiratory disease contributed to the miner's total disability. Dr. Kriengkairut conducted a comprehensive examination of the miner in 1995. Two important observations were made at this point in time. First, Dr. Kriengkairut observed that the miner experienced dsypnea on exertion and that, during an exercise test, the miner's maximum oxygen consumption was 17.5. Dr. Dolan testified at his deposition that "this exercise level shows that (the miner) wasn't even able to reach his maximum predicted heart rate because of shortness of breath." As a result, Dr. Kriengkairut found that the miner exhibited an abnormal pulmonary response to exercise. Second, Dr. Kriengkairut conducted testing of the miner's cardiovascular system and found that it responded normally to exercise, but the miner did not complain of chest pain during exercise. Indeed, Dr. Kriengkairut reported that there was "no change in cardiogram" during testing. From this, Dr. Kriengkairut reasonably concluded that the miner's disability was of a pulmonary or respiratory, not cardiac, origin.[2]

[2] Dr. Kriengkairut's opinion does not lose probative value based on treatment notes and reports from 1991 through 1995 containing diagnoses of coronary artery disease and/or atherosclerotic coronary vascular disease. Testing conducted during that time period did not reveal any impairing heart conditions; rather, the miner's testing produced normal EKG results, the miner did not complain of chest pain, and a coronary angiogram in 1991 revealed "no significant obstructive coronary artery disease." Consequently, although Dr. Kriengkairut diagnosed the presence of a heart condition, his February 1995 report makes clear that the miner was disabled from a respiratory standpoint. Testing underlying the report yielded results consistent with Dr. Kriengkairut's opinion in this regard.

Dr. Dolan agreed that the miner's coal workers' pneumoconiosis contributed to his total disability. He closely tracked the miner's treatment and hospitalization records and noted that the miner developed a respiratory ailment, which progressively worsened over the years. Specifically, Dr. Dolan stated the following in his January 1997 report:

> (The miner's) treating doctors have recorded severe respiratory symptoms, such as inability to mow even with a power mower (1991), having to stop to breathe three times walking from the parking lot to the clinic (1992), dyspnea on minimal exertion (1993), gradually worsening dyspnea on exertion (1995). He currently uses oxygen by nasal cannula. The latest pulmonary exercise test I have reviewed, dated 2/10/95, showed severe exercise limitation. He could only exercise at low exertion level for 6 minutes, dropping his oxygen saturation from 92 to 85. At an oxygen saturation of 90% (equaling a PO2 of approximately 60), most people will have the sensation of being short of breath. After his very modest exertion, with an oxygen saturation of 85% (PO2 of 53.6), he probably felt very uncomfortably short of breath. According to the physician's comments, his condition was worsening with time. On the basis of the symptoms noted by his physician and corroborated by the exercise testing, Mr. Schutt cannot perform any reasonable work and presently seems to require supplemental O2 just for activities of daily living.

Dr. Lunardi, in treatment notes dated December 1994, noted that a heart catheterization revealed no significant coronary artery disease at that time such that the miner's shortness of breath was more due to his lung condition and that he should be analyzed by a pulmonologist. The undersigned finds that Dr. Dolan's opinion is well-reasoned and well-documented.[3] It is consistent with the testing and findings of Drs. Kriengkairut and Lunardi.

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[3] At one point, Dr. Dolan also cited to the American Medical Association (AMA) guidelines to support his opinion that the miner suffered from a totally disabling respiratory impairment. In its post-hearing brief, Employer maintained the following:

> Dr. Brian Dolan, the claimant's expert, not a pulmonary specialist, concluded that there was a Class III impairment of the whole person using the AMA guidelines. (citation omitted). Dr. Repsher, who edited the second through fifth editions of the AMA's *Guidelines for the Evaluation of Permanent Impairment* chapters on pulmonary diseases explained that the exercise studies failed to reveal a pulmonary impairment but showed a class III cardiac impairment. Dr. Repsher explained the pulmonary criteria could not be used to evaluate impairment for individuals with severe heart disease or individuals in heart failure. Instead, the cardiac section is utilized. (citation omitted).

Id. at 23-24. The record does not, however, establish that the miner suffered from severe heart disease or heart failure in February 1995, when the miner exhibited "severe exercise limitation." To the contrary, Dr. Dolan specifically noted that there was no evidence that the miner suffered from any congestive heart failure at that point in time. Indeed, Dr. Kriengkairut stated, during his February 1995 testing, that the miner exhibited a "normal cardiovascular response to

Upon review of the record as a whole, it is well-documented that the miner developed progressively deteriorating respiratory symptoms, starting around 1975. These symptoms worsened without concomitant evidence of impairing cardiac problems at the time. Dr. Stoy noted, during his 1993 examination, that "cardiovascular review of (the miner's) systems (was) completely negative." In 1995, Dr. Kriengkairut found that the miner exhibited a normal cardiovascular response to exercise, but his pulmonary response was abnormal. Dr. Kriengkairut noted a severely reduced diffusing capacity during his examination of the miner and that the miner could not complete the exercise portion of the examination due to shortness of breath. Notably, the miner felt no chest pain during testing. At this point, the evidence preponderantly supports a finding that the miner suffered from a totally disabling respiratory impairment; it is evident that the miner would not be able to switch cables, walk quickly, exert force with his hands or feet, or perform the other moderately strenuous duties of his last job.

By 1996, Dr. Dolan noted that the medical records reveal continued worsening of the miner's respiratory condition (to the point that the miner used supplemental oxygen) and the development of intense cardiac problems. In 1996, the miner was hospitalized for coronary artery disease which, as noted by Dr. Dolan, was successfully treated with angioplasty. Moreover, during a 1996 hospitalization, Dr. Dolan found that a thallium test revealed right ventricular decompensation. By May 1997, he was hospitalized for congestive heart failure and, in June 1997, he suffered respiratory arrest and could not be resuscitated.

It is reasonable from the documented deterioration in the miner's health through the treatment and hospitalization records, to conclude that he was totally disabled due to a respiratory impairment stemming, in part, from coal dust exposure. Therefore, Claimant has established by a preponderance of the evidence that the miner was totally disabled due, at least in part, to coal workers' pneumoconiosis and is entitled to benefits arising from the miner's lifetime claim.

IV
Death due to coal workers' pneumoconiosis

Benefits are provided under the Act for survivors of miners who died due to pneumoconiosis. 20 C.F.R. § 718.205 (2001). The regulations at § 718.205 require competent medical evidence which (1) establishes that the miner died due to pneumoconiosis; or (2) that pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or the death was caused by complications of pneumoconiosis; or (3) that the presumption of § 718.304 is applicable.[4] Moreover, "[p]neumoconiosis is a 'substantially contributing cause' of a miner's death if it hastens the miner's death." 20 C.F.R. § 718.205(c)(5) (2001).

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exercise," but his pulmonary response was "abnormal." Thus, Dr. Dolan reasonably referenced the guidelines for pulmonary impairments.

[4] Lay evidence provisions at § 718.204(c)(5) are inapplicable to this survivor's claim because it was filed after January 1, 1982. *See also Gessner v. Director, OWCP*, 11 B.L.R. 1-1, 1-3 (1987).

Initially, physicians' opinions regarding the cause of death, which are premised on a finding of no clinical or legal pneumoconiosis, are entitled to little weight.[5] Consequently, the opinions of Drs. Naeye, Caffrey, Hutchins, Sharma, Roggli, Spagnolo, and Morgan will be accorded little weight with regard to the cause of death because they failed to diagnose clinical or legal pneumoconiosis. *See Scott, supra; Toler, supra.*

Drs. Kleinerman, Fino, Repsher, and Castle conclude that the miner died due to his cardiac problems and/or a respiratory impairment related solely to his tobacco abuse. These physicians conclude that the miner's coal workers' pneumoconiosis was so insignificant that it could not have hastened his death. However, as previously noted, the undersigned is persuaded that the combined effects of mild simple coal workers' pneumoconiosis and mild to moderately severe emphysema arising in part from coal dust exposure were totally disabling during the miner's lifetime and at the time of his death. Because Drs. Kleinerman, Repsher, Fino, and Castle did not find that the miner's emphysema was related, at least in part, to his coal dust exposure, their opinions as to the cause of death are less probative.

On the other hand, Dr. Dolan persuasively explains that the miner's coal dust-induced respiratory ailments, *i.e.* clinical coal workers' pneumoconiosis and coal dust induced emphysema, hastened his death. In particular, he noted that the miner's respiratory symptoms were present from 1975 until 1995, without data to support the presence of any concomitantly disabling cardiac disease. By 1996, the miner used supplemental oxygen. Dr. Dolan emphasized that the miner's respiratory ailments progressively worsened over time based on a review of the miner's treatment and hospitalization records. As a result, he disagreed with Dr. Lange's conclusions on the miner's death certificate:

> I was at a loss to explain why (Dr. Lange) wrote on the death certificate that the cause of death was cardiac arrest with arrhythmia due to arteriosclerotic cardiovascular disease when there's no indication that he had any further information which would sway him more toward cardiac than pulmonary.

Moreover, Dr. Dolan questioned the validity of a pathology opinion identifying the miner's death as only a cardiac event. Specifically, in reviewing Dr. Naeye's opinion on the cause of death, Dr. Dolan observed the following:

Moreover, as previously noted, Claimant has not established that the miner suffered from complicated pneumoconiosis, thus that method of finding total disability will not be discussed.

[5] The *Certificate of Death* lists the cause of death as cardiac arrest with arrhythmia due to arteriosclerotic cardiovascular disease. Dr. Lange, the cardiologist who completed the *Certificate,* does not explain his conclusions. In fact, in his emergency room report, Dr. Lange indicated that he was uncertain as to whether the miner's death was cardiac or pulmonary in nature. As a result, the death certificate does not constitute probative evidence as to the cause of the miner's death in this case. *Risher v. Office of Workers' Compensation Programs*, 940 F.2d 327, 331 (8th Cir. 1991); *Smith v. Camco Mining, Inc.*, 13 B.L.R. 1-17 (1989); *Addison v. Director, OWCP*, 11 B.L.R. 1-68 (1988).

> . . . I would agree . . . that (Dr. Naeye) is making a cardiac diagnosis with no heart to examine. I think as a pathologist he certainly would be within his area of expertise if he had a heart to examine. But he's making a cardiac diagnosis with no heart. Only the lung, and he's probably making inferences on that basis. But it might be more in the realm of conjecture rather than an actual pathological diagnosis.

Cx. 15a at 39. Dr. Dolan attributes the miner's death, in part, to his disabling respiratory impairment:

> On the day of his death (the miner) developed shortness of breath *with no mention of chest pain or dizziness as would be expected with a heart attack or an arrhythmia that cut off blood flow to his brain.* He initially stopped breathing, but began breathing again with chiropractic manipulation. However, en route to the hospital subsequently he stopped breathing again and was not able to be resuscitated.
>
> The initial note by Dr. Lange in the emergency room stated that (the miner) had ongoing lung problems and had been on continuous home oxygen since August of 1996.

Cx. 15a at 47-48 (emphasis added). Therefore, Dr. Dolan concluded that coal workers' pneumoconiosis hastened the miner's death.

Given (1) the lengthy, progressively severe, disabling respiratory impairment documented in the miner's treatment and hospitalization records, (2) the fact that the only the miner's lungs were available for pathological review and the lungs revealed significant abnormalities, and (3) the miner complained of shortness of breath immediately prior to death without chest pain or dizziness, the undersigned finds Dr. Dolan's opinion the most probative as to the cause of death. It is more probable than not that the coal dust-induced respiratory impairments hastened the miner's respiratory failure at the time of death. No other physician of record examined the miner's medical history as closely as Dr. Dolan nor did any other physician explain the progress of the miner's conditions culminating in his total disability and death as persuasively as Dr. Dolan. Dr. Dolan is a highly-qualified physician who is board-certified in internal medicine, preventative medicine, and occupational medicine. Moreover, he has a Master's degree in Public Health.

Based on the foregoing, Claimant has established by a preponderance of the evidence that the miner's death was hastened by his respiratory disease caused, at least in part, by coal dust exposure.

V
Onset of Benefits

Entitlement to miner's benefits

Claimant is entitled to benefits commencing on the date the medical evidence first establishes that he became totally disabled due to pneumoconiosis or, if such a date cannot be determined from the record, the month in which the miner filed his claim which, in this case, is February 1992. 20 C.F.R. § 725.503 (2001); *Carney v. Director, OWCP*, 11 B.L.R. 1-32 (1987); *Owens v. Jewell Smokeless Coal Corp.*, 14 B.L.R. 1-47 (1990). It is noteworthy that the date of the first medical evidence of record indicating total disability does not establish the onset date; rather, such evidence only indicates that the miner became totally disabled at some prior point in time. *Tobrey v. Director, OWCP*, 7 B.L.R. 1-407, 1-409 (1984); *Hall v. Consolidation Coal Co.*, 6 B.L.R. 1-1306, 1-1310 (1984).

Upon review of the record in this case, it is determined that the onset date is February 1995, based on Dr. Kriengkairut's observations and testing during his examination of the miner. The only physician to examine the miner prior to Dr. Kriengkairut was Dr. Stoy. In December 1993, Dr. Stoy found that the miner suffered from a respiratory impairment, most likely due to his tobacco abuse, and that he could perform some of his former job duties. Dr. Stoy did not diagnose the presence of legal or clinical coal workers' pneumoconiosis.

On the other hand, Dr. Kriengkairut found that the miner suffered from a disabling respiratory impairment arising, in part, from coal dust exposure, as supported by testing. Moreover, he opined that this impairment contributed to the miner's total disability. Dr. Kriengkairut also diagnosed the presence of coal workers' pneumoconiosis. He noted that exercise testing of the miner had to be halted due to increased dyspnea, but not chest pain. By August 1996, the miner needed to use supplemental oxygen for daily activities, and subsequent testing and examinations revealed continued deterioration of the miner's condition. There is insufficient medical data preceding Dr. Kriengkairut's examination upon which to determine the precise date on which the miner became totally disabled. Objective testing prior to February 1995 yielded non-qualifying values. On the other hand, there is medical documentation to support a finding that the miner's condition progressively worsened after Dr. Kriengkairut's examination. Therefore, it is reasonable to conclude that benefits on the living miner's claim should be awarded from February 1995.

Entitlement to survivor's benefits

Where the claimant is an eligible survivor of the miner and entitled to benefits under the Act, as in this case, such benefits must be paid beginning with the month of the miner's death but, in no instance, before January 1, 1974. 20 C.F.R. § 725.503(c). The survivor in this claim is entitled to benefits from June of 1997, the month in which the miner died. Accordingly,

ORDER

IT IS ORDERED that Employer is directed to pay benefits on claims pursued by Agnes Schutt, as the widow of and on behalf of deceased miner Benedict Schutt;

IT IS FURTHER ORDERED that benefits are payable on the claim filed by Benedict Schutt from February 1995 until May 1997, the month preceding the miner's death;

IT IS FURTHER ORDERED that survivor's benefits are payable on the claim filed by Agnes Schutt commencing as of June 1997, the month in which the miner died;

IT IS FURTHER ORDERED that Employer shall pay to Claimant's counsel, David Thompson, a total of $22,440.00 in fees based on the undersigned's June 18, 2004 *Supplemental Decision and Order Awarding Representative's Fee*, which was affirmed by the Board;

IT IS FURTHER ORDERED that, within 30 days of the date of issuance of the *Decision,* Claimant's counsel shall file, with this Office and with opposing counsel, a petition for a representatives' fees and costs since remand of this matter by the Board and in accordance with the regulatory requirements set forth at 20 C.F.R. § 725.366 (2001). Counsel for the Director and for Employer shall file any objections with this Office and with Claimant's counsel within 20 days of receipt of the petition for fees and costs. It is requested that the petition for services and costs clearly state (1) counsel's hourly rate and supporting argument or documentation therefor, (2) a clear itemization of the complexity and type of services rendered, and (3) that the petition contains a request for payment for services rendered and costs incurred before this Office only as the undersigned does not have authority to adjudicate fee petitions for work performed before the district director or appellate tribunals. *Ilkewicz v. Director, OWCP*, 4 B.L.R. 1-400 (1982).

A

Thomas M. Burke
Associate Chief Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).